

APPLICATION FOR FREE CARE

If you need assistance filling out this application please contact:

This form will be used to determine if you are eligible for Free Care or if you may qualify for health care coverage through other programs. If you are applying for someone else, please answer all questions using the applicant's information. If a section or question does not apply to you or any family member, write "N/A." If you need additional space, please use another sheet of paper.

APPLICANT INFORMATION

Last Name	First Name	MI	Social Security Number (SSN) or Tax I.D. Number (TIN) <i>(if one has been issued)</i>	
Street Address			Telephone Numbers (Home) () (Work) ()	
City	State	Zip	Mailing Address <i>(if different from street address)</i>	
Date of Birth	Are you homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>

If you are applying for someone else, please complete this section as the contact person.

Last Name	First Name	MI	Relationship to Applicant:	
Street Address			Telephone Numbers (Home) () (Work) ()	
City	State	Zip	Mailing Address <i>(if different from street address)</i>	

FAMILY INFORMATION

Please list the people in your family that live with you. Include your **spouse** and any dependent **children under age 18** that either of you may have that live with you. If you are applying for a child under age 18, please include any brothers or sisters under 18 who live with the child, and the child's parent or parents who live with the child.

Name of Family Member	SSN or TIN <i>(if one has been issued)</i>	Relationship	Date of Birth	Gender M F	Pregnant Y N
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
				<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

EARNED INCOME

Please complete this section about income (before taxes and deductions) for each family member who works.

Name of Working Family Member	Amount Earned	How Often?	Facility Use Only <i>Total Income</i>
Employer Name & Address			
Number of people who work for this employer: under 50 <input type="checkbox"/> 51-200 <input type="checkbox"/> over 200 <input type="checkbox"/> Don't know <input type="checkbox"/>			

Name of Working Family Member	Amount Earned	How Often?	Facility Use Only <i>Total Income</i>
Employer Name & Address			
Number of people who work for this employer: under 50 <input type="checkbox"/> 51-200 <input type="checkbox"/> over 200 <input type="checkbox"/> Don't know <input type="checkbox"/>			

OTHER INCOME

Please complete this section about other income (before taxes and deductions) for each family member who receives other income. Other income is money you receive that does not come from an employer.

Type of Income	Family Member(s) Receiving Income	Amount Received	How Often (circle one)	Facility Use Only <i>Total Income</i>
Social Security			Weekly, Monthly, Annually	
Railroad Retirement			Weekly, Monthly, Annually	
Veterans' Benefits			Weekly, Monthly, Annually	
Retirement Funds			Weekly, Monthly, Annually	
Annuities			Weekly, Monthly, Annually	
Pensions			Weekly, Monthly, Annually	
Child Support			Weekly, Monthly, Annually	
Alimony			Weekly, Monthly, Annually	
Unemployment			Weekly, Monthly, Annually	
Workers' Comp.			Weekly, Monthly, Annually	
Rental Income			Weekly, Monthly, Annually	
Trust Income			Weekly, Monthly, Annually	
Transitional Assistance			Weekly, Monthly, Annually	
EAEDC			Weekly, Monthly, Annually	
Dividend Income			Weekly, Monthly, Annually	
Bank Account Income			Weekly, Monthly, Annually	
Other			Weekly, Monthly, Annually	

If you or anyone listed on page 1 are **required** to make payments for alimony, child support, or a personal needs allowance for a family member in a nursing home, please fill out the section below.

Type of Payment	Recipient	Amount Paid	How Often (circle one)	Facility Use Only <i>Total Payment</i>
Alimony			Weekly, Monthly, Annually	
Child Support			Weekly, Monthly, Annually	
Personal Needs Allowance			Monthly	

OTHER INSURANCE

If you have health insurance, you may still be eligible for Free Care to pay for amounts such as copayments and deductibles.

1. Are you covered under any health insurance policy, including foreign coverage and Medicare? Yes ☐ No ☐

If yes, please provide the following information:

Policy Holder: _____ Insurer: _____ Policy Number: _____

Policy Holder: _____ Insurer: _____ Policy Number: _____

2. Are you seeking Free Care because of a work-related accident or injury? Yes ☐ No ☐

3. Are you seeking Free Care because of a motor vehicle accident? Yes ☐ No ☐

4. Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury? Yes ☐ No ☐

5. Are you a college student? Yes ☐ No ☐ If yes: Full time? ☐ Part time? ☐

6. Do you have an application pending for any of these programs? (*check all that apply*) Yes ☐ No ☐

☐ Children's Medical Security Plan ☐ MassHealth ☐ CenterCare

☐ Transitional Assistance ☐ Healthy Start ☐ EAEDC

☐ Other _____ ☐ Boston HealthNet ☐ Cambridge NetworkHealth

7. Are you currently approved for Free Care at another hospital or community health center? Yes ☐ No ☐

If yes: Where? _____

OPTIONAL QUESTION

This question is asked for data collection and analysis purposes only and in no way will be used to determine Free Care eligibility.

Race

☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander ☐ White, not Hispanic
☐ Black, not Hispanic ☐ Hispanic ☐ Other _____

ASSIGNMENT OF RIGHTS

Please read this section carefully and sign at the bottom.

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

Signature of applicant

Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

Signature of authorized representative

Date

Use This Page for Additional Information

CONDENSED APPLICATION FOR FREE CARE

If you need assistance filling out this application please contact:

APPLICANT INFORMATION

Last Name	First Name	MI	Social Security Number (SSN) or Tax I.D. Number (TIN) (if one has been issued):
Street Address			Telephone Numbers (Home) () (Work) ()
City	State	Zip	Mailing Address (if different from street address)
Date of Birth	Are you homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>		

If you are applying for someone else, please complete this section as the contact person.

Last Name	First Name	MI	Relationship to Applicant:
Street Address			Telephone Numbers (Home) () (Work) ()
City	State	Zip	Mailing Address (if different from street address)

ASSIGNMENT OF RIGHTS

Please read this section carefully and sign at the bottom.

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

Signature of applicant

Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

Signature of authorized representative

Date

APPLICATION FOR FREE CARE - MEDICAL HARDSHIP SUPPLEMENT

If you need assistance filling out this application please contact:

This form will be used to see if you are eligible for Free Care under the category of Medical Hardship. In order to qualify for Medical Hardship, you must have previously applied for Free Care and provide information showing that your medical expenses are so high that you cannot pay your medical bills. The hospital will use the information in this supplement to determine if you qualify for Medical Hardship.

Please complete all sections of this supplement. If you are applying for someone else, please answer all questions using the applicant's information. If a section or question does not apply to you or any family member, write "N/A." If you need additional space, please use another sheet of paper.

In Table 1, list all of your medical expenses from all providers. Allowable medical bills include:

- unpaid bills for which you are still responsible, incurred either before or after you applied for Free Care; and
- bills paid after the date you applied for Free Care.

In Table 2, list all of your assets except for your primary residence (where you live) and one motor vehicle. List all other assets even if you own them with another person.

APPLICANT INFORMATION

Last Name	First Name	MI	Social Security Number (SSN) or Tax I.D. Number (TIN) (if one has been issued)
Street Address			Telephone Numbers (Home) () (Work) ()
City	State	Zip	Mailing Address (if different from street address)
Date of Birth	Are you homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>		

TABLE 1: HEALTH EXPENSES

Medical Expenses	Cost	How Often Does Cost Occur?
health insurance premium		Weekly, Monthly, Annually
allowable medical bills		Weekly, Monthly, Annually
Medicare Part A premium		Weekly, Monthly, Annually
Medicare Part B premium		Weekly, Monthly, Annually

TABLE 2: ASSET INFORMATION

Do not include your primary residence (where you live) and one motor vehicle.

Asset	Owner(s)	Bank Name or Loan Holder	Account Number	Cash Value
cash				
savings accounts				
checking accounts				
term certificates				
trust accounts				
credit union accounts				
life insurance policies				
real estate				
individual retirement accounts (IRA)				
Keogh plans				
pension funds				
annuities				
boat				
motor home				
other vehicle(s)				
stocks				
bonds				
futures contracts				
money market accounts				
mutual funds				
promissory notes				
other				

SIGNATURE

Please read this section carefully and sign at the bottom.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. **I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.**

Signature of applicant

Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

Signature of authorized representative

Date

APPLICATION FOR FREE CARE – FAMILY SUPPLEMENT

APPLICANT INFORMATION

Last Name	First Name	MI	Social Security Number (SSN) or Tax I.D. Number (TIN) (if one has been issued):
Street Address			Telephone Numbers (Home) () (Work) ()
City	State	Zip	Mailing Address (if different from street address)
Date of Birth	Are you homeless? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Family member whose Free Care application contains contact and income information for this applicant:			
Last Name	First Name	MI	SSN or TIN (if one has been issued):
			Date of Birth:
If you are applying for someone else, please complete this section as the contact person.			
Last Name	First Name	MI	Relationship to Applicant:

OTHER INSURANCE

If you have health insurance, you may still be eligible for Free Care to pay for amounts such as copayments and deductibles.

1. Are you covered under any health insurance policy, including foreign coverage and Medicare? Yes ☐ No ☐

If yes, please provide the following information:

Policy Holder: _____ Insurer: _____ Policy Number: _____

Policy Holder: _____ Insurer: _____ Policy Number: _____

2. Are you seeking Free Care because of a work-related accident or injury? Yes ☐ No ☐

3. Are you seeking Free Care because of a motor vehicle accident? Yes ☐ No ☐

4. Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury? Yes ☐ No ☐

5. Are you a college student? Yes ☐ No ☐ If yes: Full time? ☐ Part time? ☐

6. Do you have an application pending for any of these programs? (check all that apply) Yes ☐ No ☐

☐ Children's Medical Security Plan

☐ MassHealth

☐ CenterCare

☐ Transitional Assistance

☐ Healthy Start

☐ EAEDC

☐ Other _____

☐ Boston HealthNet

☐ Cambridge NetworkHealth

7. Are you or the original applicant currently approved for Free Care at another hospital or community health center? Yes ☐ No ☐

If yes: Where? _____

OPTIONAL QUESTION

This question is asked for data collection and analysis purposes only and in no way will be used to determine Free Care eligibility.

Race

☐ American Indian or Alaskan Native

☐ Asian or Pacific Islander

☐ White, not Hispanic

☐ Black, not Hispanic

☐ Hispanic

☐ Other _____

ASSIGNMENT OF RIGHTS

Please read this section carefully and sign at the bottom.

I authorize my employer and my health insurer to give to this hospital or community health center information about income, health insurance premiums, coinsurance, co-payments, deductibles, and covered benefits that I have.

If I am seeking Free Care because of an accident or other incident, and I receive money because of that accident or incident from any sources, such as workers' compensation or an insurance carrier, I will repay the hospital or community health center for any medical services paid by the Free Care Pool. I give this hospital or community health center the right to collect payments from insurers for medical care as appropriate.

While I am eligible for Free Care, I agree to tell this hospital or community health center of any changes in my family status including family size, income changes, and health insurance coverage which could change my eligibility for Free Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. I authorize this hospital or community health center to give to the Division of Health Care Finance and Policy or its designee the information needed to confirm my eligibility for Free Care and to administer the Free Care Pool. I understand that this hospital or community health center cannot share confidential information, such as the information contained in this application, with any state or federal agency, except as stated above, without my prior approval.

Signature of applicant

Date

If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.

Signature of authorized representative

Date

FACILITY USE ONLY

Part I - General Information

Applicant name: _____ Date application received: _____

Medical record number: _____ Patient billing number: _____

Part II - Eligibility and Verification of Documentation

Indicate documentation being used to verify patient residency: _____

Indicate documentation being used to verify reported income: _____

- ☐ Charge of \$500 or less, no income documentation included. *If charges for this visit are \$500 or less, verification of income is not required. This is limited to once per eligibility year.*

Complete section A if using the Standard Free Care Application, or section B if using a Condensed Free Care Application. Complete sections A and C for Medical Hardship Applications.

Section A - Screening for Alternative Programs

Please explain why the patient is not enrolled in MassHealth:

- ☐ Income ineligible
- ☐ Characteristically ineligible (*see Section 4 of the application guide for an explanation of characteristically ineligible*)
- ☐ Applied but denied
- ☐ Declined to apply _____
- ☐ Asset ineligible (for patients over 65)
- ☐ Patient enrolled in MassHealth; service date prior to MassHealth eligibility/enrollment date

Section B - Reason for Condensed Free Care Application

Indicate documentation being used to support completing a Condensed Free Care Application:

- ☐ Completed MBR (*may or may not have been submitted to MassHealth*)
- ☐ MBR submitted to MassHealth with proof that the service date for free care is prior to MassHealth enrollment/eligibility date
- ☐ CenterCare enrollment or waiting list status (*signature not required if FC checked on card*)
- ☐ CMSP enrollment
 - ☐ Full Free Care (*\$0 copay for preventive care/\$1 copay for illness or injury*)
 - ☐ Partial Free Care (*\$0 copay for preventive care/\$3 copay for illness or injury*)
- ☐ EAEDC enrollment (*signature not required*)
- ☐ Healthy Start enrollment
 - ☐ Full Free Care
 - ☐ Partial Free Care (*Healthy Start card marked with red star*)
- ☐ Completed full Free Care application and supporting documentation from another hospital or community health center _____

Name of Hospital or CHC

FACILITY USE ONLY (continued)

Section C - Medical Hardship Documentation *(if applicable)*

Indicate documentation being used to verify reported assets:

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

Asset Type: _____ Documentation: _____

(If you need additional space, please attach a separate sheet.)

Part III - Facility Approval

Type of Free Care

☐ Full Free Care (<200% FPL)

☐ Denied

☐ Partial Free Care (201-400% FPL)

Deductible amount: _____

If using the Free Care application form
as an application for Medicare Indigence:

☐ Medicare Indigence *(bill to Medicare,
not to the Uncompensated Care Pool)*

☐ Medical Hardship

Contribution amount: _____

Free Care Eligibility Period

Application Date: _____ Determination Date: _____

Eligibility Begin Date: _____ End Date: _____

(Note: End date cannot be more than one year after begin date.)

Authorization

Determination Made By: _____ Approved By: _____

Title: _____ Title: _____